

**HAWAII STATE DEPARTMENT OF HEALTH**  
**ADULT HIV INFECTION CASE REPORT** (Patients >13 years of age at time of diagnosis)  
If you have used this test code previously, please use the same names to create it again this time.

LAST NAME

Date of Birth

FIRST NAME

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Month	Day	Year

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Detach and remove above this line

**Confidential**

Unnamed Test Code:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Month of Birth Helper:

Jan	0	1	Feb	0	2	Mar	0	3
Apr	0	4	May	0	5	Jun	0	6
Jul	0	7	Aug	0	8	Sep	0	9
Oct	1	0	Nov	1	1	Dec	1	2

DATE FORM COMPLETED:

Mo.	Day	Yr.

**I. DEMOGRAPHIC INFORMATION**

<b>CURRENT STATUS:</b> Alive <input type="checkbox"/> 1 Dead <input type="checkbox"/> 2 Unk. <input type="checkbox"/> 9	<b>AGE AT DIAGNOSIS:</b> ____ Years	<b>DATE OF DEATH:</b> Mo. ____ Day ____ Yr. ____	<b>STATE/TERRITORY OF DEATH:</b> _____
<b>SEX:</b> <input type="checkbox"/> 1 Male <input type="checkbox"/> 2 Female <input type="checkbox"/> Transgendered male to female <input type="checkbox"/> Transgendered female to male			
<b>RACE/ETHNICITY</b> <input type="checkbox"/> 1 White (not Hispanic) <input type="checkbox"/> 4 Asian/Pacific Islander: <input type="checkbox"/> 2 Black (not Hispanic) <input type="checkbox"/> 5 American Indian/Alaska Native <input type="checkbox"/> 3 Hispanic <input type="checkbox"/> 9 Not Specified Hawaiian <input type="checkbox"/> Japanese <input type="checkbox"/> Filipino <input type="checkbox"/> Chinese <input type="checkbox"/> Other (specify) _____		<b>COUNTRY OF BIRTH:</b> <input type="checkbox"/> 1 U.S. <input type="checkbox"/> 7 U.S. Dependencies and Possessions (including Puerto Rico) (specify) _____ <input type="checkbox"/> 8 Other (specify) _____ <input type="checkbox"/> 9 Unknown	
<b>RESIDENCE AT DIAGNOSIS:</b> City: _____ County: _____ State/Country: _____ Zip Code: _____			

**II. PREVIOUS HIV TESTS**

- Did the patient use this test code before in Hawaii? Yes ☐ 1 No ☐ 0
- If yes, was same name used to create this test code? Yes ☐ 1 No ☐ 0
- Did the patient test HIV + in another state? Yes ☐ 1 No ☐ 0
- If yes, please give:
1. State name: \_\_\_\_\_
2. Date of test: Mo. \_\_\_\_ Yr. \_\_\_\_

This report to the Department of Health is required by §325-2, Hawaii Revised Statutes (HRS), and §11-156-8.8, Hawaii Administrative Rules. Your cooperation is necessary for the understanding and control of HIV/AIDS. The confidentiality of all information submitted is protected by Chapter 92F and §325-101, HRS.

**III. PATIENT HISTORY**

**AFTER 1977 AND PRECEDING THE FIRST POSITIVE HIV ANTIBODY TEST OR AIDS DIAGNOSIS, THIS PATIENT HAD** (Respond to ALL Categories):

- |  | Yes  | No   | Unk.   |
|--|--|--|--|
| • Sex with male.....   | <input type="checkbox"/> 1   | <input type="checkbox"/> 0   | <input type="checkbox"/> 9   |
| • Sex with female.....   | <input type="checkbox"/> 1   | <input type="checkbox"/> 0   | <input type="checkbox"/> 9   |
| • Injected nonprescription drugs.....  | <input type="checkbox"/> 1   | <input type="checkbox"/> 0   | <input type="checkbox"/> 9   |
| • Received clotting factor for hemophilia/coagulation disorder.....<br>Specify <input type="checkbox"/> 1 Factor VIII (Hemophilia A) <input type="checkbox"/> 2 Factor IX (Hemophilia B) <input type="checkbox"/> 8 Other (Specify): _____   | <input type="checkbox"/> 1   | <input type="checkbox"/> 0   | <input type="checkbox"/> 9   |
| • <b>HETEROSEXUAL</b> relations with any of the following:<br>• Intravenous/injection drug user.....<br>• Bisexual male.....<br>• Person with hemophilia/coagulation disorder.....<br>• Transfusion recipient with documented HIV infection.....<br>• Transplant recipient with documented HIV infection.....<br>• Person with AIDS or documented HIV infection, risk not specified..... | <input type="checkbox"/> 1<br><input type="checkbox"/> 1<br><input type="checkbox"/> 1<br><input type="checkbox"/> 1<br><input type="checkbox"/> 1<br><input type="checkbox"/> 1 | <input type="checkbox"/> 0<br><input type="checkbox"/> 0<br><input type="checkbox"/> 0<br><input type="checkbox"/> 0<br><input type="checkbox"/> 0<br><input type="checkbox"/> 0 | <input type="checkbox"/> 9<br><input type="checkbox"/> 9<br><input type="checkbox"/> 9<br><input type="checkbox"/> 9<br><input type="checkbox"/> 9<br><input type="checkbox"/> 9 |
| • Received transfusion of blood/blood components (other than clotting factor).....<br>Mo. ____ Yr. ____ First ____ Last ____   | <input type="checkbox"/> 1   | <input type="checkbox"/> 0   | <input type="checkbox"/> 9   |
| • Received transplant of tissue/organs or artificial insemination.....   | <input type="checkbox"/> 1   | <input type="checkbox"/> 0   | <input type="checkbox"/> 9   |
| • Worked in a health-care or clinical laboratory setting.....<br>(specify occupation): _____   | <input type="checkbox"/> 1   | <input type="checkbox"/> 0   | <input type="checkbox"/> 9   |

**IV. FACILITY OF DIAGNOSIS**

Facility Name _____ State/Country _____	
<b>FACILITY SETTING</b> (check one) <input type="checkbox"/> 1 Public <input type="checkbox"/> 2 Private <input type="checkbox"/> 3 Federal <input type="checkbox"/> 9 Unknown	<b>FACILITY TYPE</b> (check one) <input type="checkbox"/> 01 Physician, HMO <input type="checkbox"/> 31 Hospital, Inpatient <input type="checkbox"/> 88 Other (specify): _____
Physician's Name: _____ Phone No.: ( ) _____ Medical Record No.: _____ (Last, First, M.I.) Hospital/Facility: _____ Person Completing Form: _____ Phone No.: ( ) _____	

## V. LABORATORY DATA

### 1. HIV ANTIBODY TEST AT DIAGNOSIS:

(Indicate first test)

	Pos	Neg	Ind	Not Done	TEST DATE	
					Mo.	Yr.
• HIV-1 EIA.....	1	0	-	9		
• HIV-1/HIV-2 combination EIA.....	1	0	-	9		
• HIV-1 Western blot/IFA.....	1	0	8	9		
• Other HIV antibody test.....	1	0	8	9		

(specify): \_\_\_\_\_

### 2. POSITIVE HIV DETECTION TEST: (Record earliest test)

☐ culture ☐ antigen ☐ PCR, DNA or RNA probe

• Other (specify): \_\_\_\_\_

### 3. DETECTABLE VIRAL LOAD TEST: (Record most recent test)

Test type\* ☐ COPIES/ML ☐ Mo. ☐ Yr. ☐

\*Type: 11. NASBA (Organon) 12. RT-PCR (Roche) 13. bDNA(Chiron) 18. Other

• Date of last documented negative HIV test (specify type) \_\_\_\_\_ Mo. ☐ Yr. ☐

• If HIV laboratory test were not documented, is HIV diagnosis documented by a physician?..... Yes ☐ No ☐ Unk. ☐

If yes, provide date of documented by physician..... Mo. ☐ Yr. ☐

### 4. IMMUNOLOGIC LAB TESTS: (Voluntary)

AT OR CLOSEST TO CURRENT DIAGNOSTIC STATUS

• CD4 Count ..... ☐ ☐ ☐ cells/μL Mo. ☐ Yr. ☐

• CD4 Percent ..... ☐ % Mo. ☐ Yr. ☐

### 5. Other:

• Laboratory Name: \_\_\_\_\_

• Accession No.: \_\_\_\_\_

## VI. TREATMENT/SERVICES REFERRALS

Has this patient been informed of his/her HIV infection? ☐ Yes ☐ No ☐ Unk.

This patient's partners will be notified about their HIV exposure and counseled by:

☐ Health department ☐ Physician/provider ☐ Patient ☐ Unknown

This patient received or is receiving:

• Anti-retroviral therapy ..... Yes ☐ No ☐ Unk. ☐

• PCP prophylaxis ..... Yes ☐ No ☐ Unk. ☐

This patient has been enrolled at:

Clinical Trial ☐ NIH-sponsored ☐ HRSA-sponsored

☐ Other ☐ Other

☐ None ☐ None

☐ Unknown ☐ Unknown

This patient is receiving or has been referred for:

• HIV related medical services ..... Yes ☐ No ☐ NA ☐ Unk. ☐

• Substance abuse treatment services ☐ ☐ ☐ ☐

This patient's medical treatment is primarily reimbursed by:

☐ Medicaid ☐ Private insurance/HMO

☐ No coverage ☐ Other Public Funding

☐ Clinical trial/ government program ☐ Unknown

### FOR WOMEN:

• This patient is receiving or has been referred for gynecological or obstetrical services: ..... ☐ Yes ☐ No ☐ Unknown

• Is this patient currently pregnant? ..... ☐ Yes ☐ No ☐ Unknown

• Has this patient delivered live-born infants? ..... ☐ Yes (if delivered after 1977, provide birth information below for the most recent birth) ☐ No ☐ Unknown

CHILD'S DATE OF BIRTH: Mo. ☐ Day ☐ Yr. ☐

Hospital of Birth: \_\_\_\_\_ City \_\_\_\_\_ State: \_\_\_\_\_

## VII. REQUESTED INFORMATION

• Does this patient have symptomatic AIDS or CD4 count <200 cell/μL or <14%? Yes ☐ No ☐

If yes, please attach an AIDS Case Report form and write down the patient's name, date of birth and Section VIII (AIDS indicator disease) and/or CD4 Count.

For Official Use Only: ☐ New Report ☐ Update

Case No.: ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

## VIII. COMMENTS

## RACE/ETHNIC BACKGROUND FORM

### 1. ETHNICITY: (Please select one)

☐ 1 Hispanic ☐ 2 Not Hispanic or Latino ☐ 9 Unknown

### 2. RACE: (Please select one or more)

☐ White ☐ Black or African American ☐ Unknown  
☐ Asian ☐ Native Hawaiian or Other Pacific Islander

### 3. FOR ASIANS OR HAWAIIAN/ PACIFIC ISLANDERS

(Please select one or more)

#### ASIANS:

☐ 01 Japanese  
☐ 02 Filipino  
☐ 03 Chinese  
☐ 06 Korean  
☐ 17 Vietnamese  
☐ 18 Laotian  
☐ 19 Thai  
☐ 20 Cambodian  
☐ 21 Indonesian  
☐ 22 Asian Indian  
☐ 23 Other Asian  
☐ 24 Pakistani  
☐ 25 Malaysian

#### HAWAIIAN / PACIFIC ISLANDERS:

☐ 04 Hawaiian  
☐ 07 Samoan  
☐ 08 Guamanian  
☐ 09 Tongan  
☐ 10 Fijian  
☐ 11 Marshallese  
☐ 12 Micronesian  
☐ 13 Tahitian  
☐ 14 Northern Mariana  
☐ 15 Palauan  
☐ 16 Other Pac. Islander  
☐ 26 Polynesian